

**DECEASED** **1 1948**

Registration District No. **799**

Primary Registration District No. **1002**

**1. PLACE OF DEATH:**

(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Research Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **6 weeks**  
In this community **20 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Lillian M. ORR**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **500-16-8645**

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Lester T. Orr** 6. (c) Age of husband or wife if alive **41** years  
7. Birth date of deceased **March 22, 1906**  
(Month) (Day) (Year)

8. AGE: Years **42** Months **5** Days **29** If less than one day hr. min.

9. Birthplace **Thomasville, Arkansas**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **At home**

12. Name **Thomas J. Reed**  
13. Birthplace **California, Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Charlotte Stephens**  
15. Birthplace **Old Linn Creek, Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Lester T. Orr**  
(b) Address **1211 Troost Ave., K.C., Mo.**  
17. (a) **Burial** (b) Date thereof **9-23-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Floral Hills**  
18. (a) Signature of funeral director **Melody-McGilley-Eylar**  
(b) Address **Kansas City, Missouri**

19. (a) **9-22-48** (b) **Geraldine Holmes**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1211 Troost Avenue**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Sept.** day **21**  
year **1948** hour **7** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **5-20-47** to **9-21-48**  
that I last saw her alive on **9-20-48**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**

Due to **carcinoma cervix**

Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy **pelvic carcinoma**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) Means of injury  
23. Signature **W. H. [illegible]** (M. D. or other)  
Address **830 Argyle Bldg** Date signed **9/22/48**

Dr. S. H. Lockwood  
2-4- Wednesday -  
Argyle Bldg

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.